



Vaping-Related Lung Illness Case Report Form

Instructions

Complete this form to report cases of lung injury/illness of unclear etiology and a history of e-cigarette or vaping product use within 90 days prior to symptom onset.

Please attach the following medical records (as applicable):

- Face sheet
- History and Physical
- Progress Notes
- Chest X-ray/CT Results
- Lab Results, including:
 - Respiratory Viral Panel
 - Influenza A and B
 - Other Infectious Disease Results
- Discharge Summary

**Submit to Wichita Falls–Wichita County Public Health District via
Fax 940-761-7659.**

Additional Information for Clinicians

If e-cigarette product use, or vaping, is suspected as a possible cause for a patient's symptoms, a detailed history of the substances used, the devices used, and the sources of the devices and substances, should be obtained, as outlined in the [CDC Health Alert Network \(HAN\)](#) released August 30, 2019. Determine if any remaining products or liquids used in vaping devices are available for testing, and ask that these be set aside.

If you are interested in submitting **clinical** (bronchoalveolar lavage, serum, urine, or lung biopsy tissues) or **vaping product** samples for testing, please contact DSHS (512-442-0925 or epitox@dshs.texas.gov) for further instructions after submitting this report form.

Additional recommendations for clinicians are available at www.cdc.gov/lunginjury.



Vaping-Related Lung Illness Case Report Form

1. REPORTER INFORMATION Date: <input style="width:100%;" type="text"/> Reported by: <input style="width:100%;" type="text"/> Affiliation: <input style="width:100%;" type="text"/> Phone: <input style="width:100%;" type="text"/> Email: <input style="width:100%;" type="text"/>	2. FACILITY INFORMATION Facility Name: <input style="width:100%;" type="text"/> Facility City: <input style="width:100%;" type="text"/> Provider Name: <input style="width:100%;" type="text"/> Provider Phone: <input style="width:100%;" type="text"/>	3. ATTACHED RECORDS <input type="checkbox"/> Patient Face Sheet <input type="checkbox"/> History and Physical <input type="checkbox"/> Progress Notes <input type="checkbox"/> Chest X-Ray/CT Results <input type="checkbox"/> Lab Results <input type="checkbox"/> Respiratory Viral Panel <input type="checkbox"/> Influenza A and B <input type="checkbox"/> Other Infectious Disease Results <input type="checkbox"/> Discharge Summary																
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7. LABORATORY SPECIMEN <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> Biological specimen available for testing? <input type="checkbox"/> Bronchoalveolar lavage (BAL) fluid <input type="checkbox"/> Lung biopsy tissue (Formalin-fixed (wet) tissues or formalin-fixed paraffin-embedded lung tissue blocks) <input type="checkbox"/> Other (<i>describe</i>): </td> <td style="width:50%; vertical-align: top;"> E-cigarette/vaping product samples available for testing? <input type="checkbox"/> Liquids (<i>e.g.</i>, cartridges or pods) <input type="checkbox"/> Device(s) <input type="checkbox"/> Other (<i>describe</i>): </td> </tr> </table>			Biological specimen available for testing? <input type="checkbox"/> Bronchoalveolar lavage (BAL) fluid <input type="checkbox"/> Lung biopsy tissue (Formalin-fixed (wet) tissues or formalin-fixed paraffin-embedded lung tissue blocks) <input type="checkbox"/> Other (<i>describe</i>):	E-cigarette/vaping product samples available for testing? <input type="checkbox"/> Liquids (<i>e.g.</i> , cartridges or pods) <input type="checkbox"/> Device(s) <input type="checkbox"/> Other (<i>describe</i>):														
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<p>8. CHEST X-RAY</p> <p>Chest X-ray completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Infiltrate or opacity present? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical findings:</p>	<p>9. CT-SCAN</p> <p>CT scan completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ground glass opacity present? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical findings:</p>						
<p>10. INFECTIOUS DISEASE (ID) AND RESPIRATORY VIRAL PANEL (RVP)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p>RVP Results</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Completed</td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p>Influenza A</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Completed</td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p>Influenza B</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Completed</td> </tr> <tr> <td style="vertical-align: top; padding: 5px;"> <p>Additional Infectious Disease Testing Completed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="vertical-align: top; padding: 5px;"> <p>Significant Positive ID Findings?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="vertical-align: top; padding: 5px;"> <p>Infectious Etiology Explains Current Illness?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p>Briefly describe clinical assessment, including findings from specialist consultations or other diagnostic lab tests:</p>		<p>RVP Results</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Completed	<p>Influenza A</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Completed	<p>Influenza B</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Completed	<p>Additional Infectious Disease Testing Completed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Significant Positive ID Findings?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Infectious Etiology Explains Current Illness?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<p>11. DO OTHER MEDICAL CONDITIONS EXPLAIN PRESENTATION OF ILLNESS?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Briefly explain clinical reasoning:</p>	<p>12. E-CIGARETTE/VAPING</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; vertical-align: top; padding: 5px;"> <p>History of vaping:</p> <input type="checkbox"/> THC Products <input type="checkbox"/> Nicotine Products <input type="checkbox"/> Other</td> <td style="width: 40%; vertical-align: top; padding: 5px;"> <p>Vaped in 90 days prior to symptom onset:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <p>Products vaped and history:</p> </td> </tr> </table>	<p>History of vaping:</p> <input type="checkbox"/> THC Products <input type="checkbox"/> Nicotine Products <input type="checkbox"/> Other	<p>Vaped in 90 days prior to symptom onset:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Products vaped and history:</p>			
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